IN THE UNITED STATES COURT FOR THE DISTRICT OF UTAH
CENTRAL DIVISION

ROY STEGELMEIER, personal representative of the Estate of Trudy Stegelmeier, Plaintiff, vs. DOUG ANDRUS DISTRIBUTING INC. EMPLOYEE HEALTH BENEFIT PLAN, HEBER ANDRUS, Defendants.	MEMORANDUM ORDER DENYING PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT AND REMANDING CASE TO PLAN ADMINISTRATOR Case No. 2:02-CV-238 TS

This matter is before the court on Plaintiff's Motion for Summary Judgment. The court having considered the Motion, the memoranda, supporting materials and being fully advised does find and conclude as follows:

I. INTRODUCTION

This case is brought under ERISA and HIPPA.[1] Plaintiff is the widower of Trudy Stegelmeier and the personal representative of her estate. At issue is the denial of

[1] Employee Retirement Income Security Act of 1974 (ERISA) and Health Insurance Portability and Accountability Act of 1996 (HIPPA).

44

Plaintiff's claim for benefits for expenses incurred in his wife's final surgery and hospitalization because he did not submit a certificate showing his wife's prior insurance coverage as was required under HIPPA to avoid a pre-existing condition exclusion. The undisputed facts show that Defendants failed to comply with ERISA by failing to notify Plaintiff that (1) the claims were denied because there was not adequate proof of prior coverage or (2) of the procedures to appeal denials of claims. In his Motion for Summary Judgment, Plaintiff contends that this failure entitles him to a *de novo* review of the denial and award of benefits. However, the appropriate remedy where the Claims Administrator and Plan Administrator failed to comply with ERISA's procedural guidelines by failing to provide adequate notice, is to remand to the Plan Administrator for a redetermination of the claim. Accordingly, the court will deny summary judgment and remand this case for further proceedings.

II. UNDISPUTED FACTS

Claimant and plaintiff Roy Stegelmeier (Stegelmeier) was the husband of Trudy Stegelmeier and is the personal representative of her estate. He was employed by Doug Andrus Distributing, Inc., and he and his dependents were participants and beneficiaries in the Doug Andrus Distributing Benefit Plan (the Plan). On December 10, 1998, Mr. Stegelmeier completed the paperwork to enroll his wife Trudy, and she became a Plan beneficiary on January 1, 1999.

The Plan and the Summary Plan Description (SPD) were available for inspection at the offices of Andrus Distributing and copies of the Plan and the SPD were distributed to Mr. Stegelmeier within a short time after he started work for the company.

The Plan is a group medical benefits plan sponsored by Doug Andrus Distributing, Inc. for its employees and their beneficiaries. The Plan is also an employee welfare benefit plan under 29 U.S.C. §1002(1) of ERISA.

Heber Andrus is the Plan Administrator and the named fiduciary for the Plan. The Plan is funded by employer and employee contributions. Employee Benefit Management, Inc. (EBMS) is the third party administrator for the Plan.

The Plan provides as follows:

PLAN ADMINISTRATOR.

* * *

> The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which related to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

DUTIES OF THE PLAN ADMINISTRATOR.

* * *

> (9) To delegate to any person or entity such powers, duties and responsibilities

* * *

WHEN CLAIMS SHOULD BE FILED

* * *

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information will be requested from the claimant.

* * *

If a claim is wholly or partially denied, the Claims Administrator will furnish the Plan Participant with a written notice of this denial. . . . This written notice will contain the following information:

a. The specific reason or reasons for the denial:

b. Specific reference to those Plan provisions on which the denial is based;

c. A description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary; and

d. Appropriate information as to the steps to be taken if a Plan Participant wishes to submit the claim for review.

* * *

In cases where a claim for benefits payment is denied in whole or in part ...

* * *

The request for review must be directed to the Plan Administrator within 60 days after . . . the date of the notification of denial of benefits.

* * *

A Plan Participant must exhaust the claims appeal procedure before filing a suit for benefits.

Ex. B (underlined emphasis added).

Under the Plan, coverage was provided for medically necessary inpatient care. However, there was a Pre-Existing Condition Limitation for new enrollees which states:

> Covered charges incurred under Medical Benefits for Pre-Existing Conditions are not payable unless incurred 12 consecutive months, or 18 months if a Late Enrollee after the person's Enrollment Date. This time may be offset if the Employee has creditable coverage from his or her previous plan.

Pl.'s Ex. B, 000179 (underlined emphasis added).

The Plan defines Pre-Existing Condition as:

> A Pre-Existing Condition is a condition for which medical advice, diagnosis, care of treatment was recommended or received within six months of the person's Enrollment Date under this Plan.

Ex. B, 000179.

Under the terms of the Plan, the employer had responsibility to assist participants and beneficiaries in obtaining and/or verifying prior coverage as follows.[2]

> PRE-EXISTING CONDITIONS
>
> NOTE: The length of the Pre-Existing Condition Limitation may be reduced or eliminated if any eligible person has creditable coverage from another health plan. An eligible person may request a certificate of creditable coverage from his or her prior plan and the Employer will assist any eligible person in obtaining a certificate of creditable coverage from a prior plan.
>
> If, after creditable coverage has been taken into account, there will still be a Pre-Existing Conditions Limitation imposed on an individual, that individual will he so notified.

Ex. B, at 000179.

---

[2]*Compare* 29 C.F.R. § 2590.701-5 (c) and (d) (Plan's duties as part of procedures to establish evidence of creditable coverage when an individual unable to obtain a certificate when needed).

This pre-existing exclusion would no longer bar coverage for Trudy Stegelmeier's pre-existing conditions after January 1, 2000.

The Plan has a Service Agreement[3] with EBMS, which provides that EBMS will perform the following administrative services for the Plan sponsor:

> (b) *Process and adjudicate all claims presented for payment, including but* not limited to reasonable investigatory work in determining claim eligibility, and preparing an distributing benefit checks or drafts to employees and/or service providers.
>
> * * *
>
> (d) Respond to inquires from . . . Plan Members and service providers concerning requirement, procedures or benefits of the Plan, though such information shall not constitute a determination of benefits that will be paid under the Plan or a guarantee or certification to anyone that any amount will be paid.

Service Plan.

Trudy had two policies of insurance with Combined Insurance Company of America (Combined). One policy was a "Sickness Income Policy" which provided reimbursement for lost time during sickness, with increased benefits during a period of hospitalization, if the insured is disabled. *The second policy also provided a set benefit during a period of* hospitalization, without regard to disability. Ex. C.

The Combined policies became effective on October 16, 1997, and December 8, 1997, respectively. Both policies were in effect through the date of Trudy's death. Ex. A, D00427.

---

[3]*Employee Benefit Management Services, Inc., Administative Services* Agreement for Doug Anrus Distributing, Inc. (Services Agreement). Andrus Aff., Ex. 1.

The Combined policies provide differing coverage: One pays in connection with a disability. The other pays benefits both in connection with a disability (Sections A, B. and C) and, in a separate Section E, for a set amount for hospital expenses.

The policy provides:

SICKNESS HOSPITAL INDEMNITY POLICY

This Policy is Guaranteed Renewable and Provides an Indemnity for Hospitalization Caused by Sickness

* * *

SECTION E ADDITIONAL HOSPITAL EXPENSE – SICKNESS

If, because of a covered sickness and beginning while this policy is in force, you are confined in a hospital overnight as an inpatient, Combined will pay you, in addition to any other benefits payable under this policy the hospital expenses you incur up to . . . $200.00 for each period of such hospital confinement.

* * *

(2) HOSPITAL CONFINEMENT INDEMNITY COVERAGE – Policies of this category are designed to provide, to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered sickness, subject to any limitation set forth in the policy. Such policies do not provide any benefit other than the fixed daily indemnity for hospital confinement and any additional benefit described below.

(3) DESCRIPTION OF BENEFITS –SICKNESS ONLY COVERAGE

* * *

E.

Additional Hospital Benefit . . . Up to $200 for each confinement.

> MEDICARE SUPPLEMENT CONVERSION – Upon attainment of age 65 you are eligible for a Medicare Supplement Policy without evidence of insurability.

Ex. C.

Following Trudy's death and upon receipt of a claim for benefits from her widower, Combined made payment in the amount of $5,531.00 under Trudy's policies of insurance for "hospital confinement, intensive care unit, and hospital incidentals." Ex. D. Of the amount paid by Combined, $200 was under Section E as an indemnity for the hospital confinement. *Id.*

Trudy had a variety of serious health problems. In the summer of 1999, her physician, Dr. Goodman, recommended surgery. He requested pre-authorization from EBMS for the procedure on August 10, 1999. Ex. A, D00244. On September 3, 1999, EBMS responded affirmatively to the preauthorization request. Ex. A, D00287. However, the September 3, 1999, pre-authorization expressly provided that the pre-authorization was "based on the information provided by the Doctor's office" and that the procedure "would [only] be considered an eligible expense subject to plan provisions, UCR and eligibility at the time charges are incurred." It further provided that the pre-authorization was "not a guarantee of benefits. Charges are subject to eligibility and plan provisions at the time charges are incurred." *Id.*

Approximately one month to six weeks prior to the surgery in October 1999, Carisa from Dr. Goodman's office called EBMS to verify benefits. Carisa and Kellie, an EBMS employee, discussed, among other things, the need for evidence of prior coverage from

Trudy to eliminate the pre-existing condition waiting period. An excerpt from the undated transcript reads:

> Kellie: For the surgeon charges?
>
> Carisa[4]: Yes.
>
> Kellie: Ok. Her effective date was 1/1 of '99, um, let's see, I see they've done a pre-op in our CARE LINE Department so that's ok. Her deductible would be $300.00 per calendar year. Of course, I also have to tell you this a non-guarantee of payment.
>
> Carisa: Ok.
>
> * * *
>
> Carisa: Ok. And, since she was just active on 1/1/99, is there any pre-existing?
>
> Kellie: I need to look in another place, here, just one second. Possibly, I'm not sure. She may have had other insurance, because her husband has this insurance since September and I don't know why she's only come on now. So, she might have had something else. So, it would be a question.
>
> Carisa: So, just call the patient and make sure that she takes care of that?
>
> Kellie: Yeah, you might just tell her to let — notify us of any previous coverage before this plan.
>
> Charisa: Ok.

Ex. A, D00563.

In the weeks and months before the surgery, Trudy had three separate conversations with Kellie at EBMS concerning the pre-existing conditions limitation, HIPPA,

---

[4]The transcript spells the name Carisa as "Charisa" and Mrs. Stegelmeier's name as "Trudi." Those spellings have been changed in this opinion for clarity and consistency.

and creditable coverage. The EBMS records do not reflect the dates of these conversations. Excerpts from the transcripts of those telephone conversations follow:

Trudy: Hello.

Kellie: Hi, Trudy, this is Kellie at EBMS in Billings, Montana.

Trudy: Yes.

Kellie: I'm calling you back and I do just need to tell you quickly that the call is recorded for quality assurance. Ok?

Trudy: Ok.

Kellie: Now, um, the reason I wanted you to call was I see you've been on this policy since January of this year.

Trudy: Yeah.

Kellie: Did you have insurance prior to — to this plan?

Trudy: Yes.

Kellie: Ok. Were you covered for at least 12 months?

Trudy: Yes.

Kellie: Ok. If you could get a certificate of coverage from that other insurance and send it in to us.

Trudy: How do you do that?

Kellie: You just call them and you tell them you need a certificate showing what your coverage dates were and they are used to this because they do it all the time. It just shows when you started coverage and when you ended coverage. And, that way then pre-existing is not an issue because in order for you to not have pre-existing conditions apply, you'd have to be on the policy for at least a year and since you, it has, it's getting close, but it hasn't been yet. So, I would have to be sending for records and all kinds of things like that. So, if you could just send in that certificate from the other insurance

showing how long you had coverage and what the dates were, then that's all we need. Ok?

Trudy: They call it a certificate of insurance? Or . . .

Kellie: Yeah, it's actually called — it's actually called a HIPAA certificate. And it's just . . .

* * *

Kellie: Yeah, it's an abbreviation for this act in law that shows if you have coverage from one insurance and you change to another one that they take into consideration the amount of time you had coverage before so you're not starting all over again with waiting periods and things like that. And, they'll know what it is. If you just call the customer service person at the other insurance. Who did you have it through?

Trudy: Combined Insurance.

Kellie: Was that in Idaho?

Trudy: Uhm, it's uh, let's see where is it at? I can't remember, Minnesota or something.

Kellie: Ok.

Trudy: It's a national insurance.

Kellie: Was it through your work or something?

Trudy: No.

Kellie: Oh. ok.

Trudy: Just one that I had personally.

Kellie: Ok. But, it was a medical plan, right?

Trudy: A medical, um hum — a hospital medical thing.

Kellie: Ok.

Trudy: I have, urn, how they first started coming round was for accidents.

Kellie: Oh, yeah. Ok, and this covered doctor's visits and everything, right?

Trudy: It was all of that.

Kellie: Ok.

Trudy: So, I can . . .

Kellie: Yeah, just give them a call and ask . . . tell them that you need that because you are now on another insurance and they'll understand because they do this all the time. And, then just go ahead and send it in to the address on the back of your insurance card and then we can get that information in.

Trudy: On that back of the insurance card is the address, huh?

Kellie: Yeah, the P.O. Box in Billings, Montana.

Trudy: Ok. Ok.

Kellie: Do you know roughly how long you had the other insurance? Was it quite awhile?

Trudy: Yeah. Five years, something like that.

Kellie: Ok. I'm just going to make a note in your file so that if I get claims in the meantime, then I see this information. So, if you could get that certificate and send it in and then everything — then I can process claims right away. I won't have to send for records or anything like that. Ok?

Trudy: Ok, I'll call them and have them do that then.

Kellie: Ok. That would . . .

Trudy: Thanks.

* * *

Voice mail left with Kellie, 12:15 p.m., from Trudy Stegelmeier:

Kellie, this is Trudy Stegelmeier, again, in Ashton. Could you please give me a call at 652-7391. I have another question. Bye.

* * *

1:38 p.m. [unknown date]

Trudy: Hello.

Kellie: Hi, Trudy, this is Kellie at EBMS in Billings.

Trudy: Ok. Urn, I did call the insurance company and they will send, uh, a certificate.

Kellie: Ok.

Trudy: Ok?

Kellie: Right.

Trudy: What is [sic] indemnity policy mean?

Kellie: I'm not sure. Did they mention that?

Trudy: Um huh.

Kellie: Is that what kind of policy it was? Did they say, or . . .

Trudy: Well, one of them, I guess.

Kellie: I'm not really sure, urn, I'd have to look at it to see so I think just send it in when you get it and then we'll go from there.

Trudy: Ok.

Kellie: I mean right now you do have the medical coverage so without seeing it I can't really say. There's so many different things.

Trudy: Ok.

Kellie: Ok? So just keep a copy for your records and then send us in the original.

* * *

4:04 p.m [unknown date]

Kellie: Hi, is this Trudy?

Trudy: Yes it is. . . . After you get this information, how much time am I looking at? I mean it's been like, oh, two months already.

Kellie: Well, it depends if I'm, um, I don't think I'm holding any claims on you right now, that I've pended for records or anything. Let me just check. No, I don't have anything on hold right now so once that comes in and, you know, it normally doesn't take very long to be verified. They just have to verify it and then that's it. So, probably before I get any claims in, we'll have it. So . . .

Trudy: In other words then I could go ahead and schedule it, or . . .

Kellie: Now, what are you going to have done?

Trudy: It's uh, I'm having — evidently having some problems with my liver I guess.

Kellie: Ok.

Trudy: This has just showed up, so . . .

Kellie: Ok. Yeah, I would go ahead. I wouldn't wait because I mean . . .

Trudy: A type of cirrhosis they tell me that can be corrected.

Kellie: Right.

Trudy: With this surgery and I just don't know they just should tell me we can wait but it'll just depend on how your body is.

Kellie: Well, I certainly wouldn't want you to. . .

Trudy: . . . trouble the more I wait. I don't know.

Kellie: Yeah, I certainly wouldn't want you to wait. If you've had coverage, you know, if you've had medical coverage for at least a year prior to you coming on with Doug Andrus, I, you know, I wouldn't even worry, because we take that into consideration and you don't have pre-existing. You know, I can't

guarantee how we're going to pay anything, but the other thing that I would have to do is, once I get a claim, if I don't have that information, then I have to send for records from the doctor and, you know, that takes longer and everything.

Trudy: Now, what is pre-existing?

Kellie: That means you have been treated or seen for a specific condition within six months prior to your effective date with us. So, the if I would find that you had, when I got records, then I would have to deny it as pre-existing. But, with this certificate showing that you had coverage, then that doesn't apply to you. Then, there is no pre-existing to even look for.

Trudy: So, alright.

Kellie: Yeah. So, once I get that — the certificate, you know, you don't have anything to — it's just like you continued from their insurance on to ours and there's no waiting periods or anything like that for your medical claims. Ok?

Trudy: Ok.

Kellie: So, and I wouldn't wait, you know, I mean, if they — if you want to have this done, then don't wait just until you get the ok from this because, you know, you know you had the coverage and I don't want your health to suffer in the meantime waiting so, ok?

Trudy: So, if it says, anyway I don't know. What did I ask you about that insurance policy, they tell me it was indemnity? What does that mean?

Kellie: Did you just have the one type of policy?

Trudy: No, I have um, now there's several under that Combined Insurance. There's a hospital, uh, sickness and accident.

Kellie: Right.

Trudy: Uh. . .

Kellie: Well, as long as that's creditable coverage, then, you know, that pertains.

Trudy: Uh huh.

Kellie: I mean, if you just had like a supplemental accident policy or just a life policy or something, that's not the right kind, but if you had a medical plan that is, you know, considered a regular, you know, what you submit your bills to after you go to the doctor, then that's a creditable coverage.

Trudy: Ok.

Kellie: Ok?

Trudy: All right, well I guess we'll see.

Kellie: Ok.

Trudy: .... send that in.

Kellie: Ok.

Trudy: There's so much stuff to do.

Kellie: Yeah, it's kind of, you know, just when you transfer policies. Just until we get everything up and running and get all the information that we need, so.

Kellie: Well, just send it in when you get it and we can't [sic] look at it and make sure what it is, so ...

Trudy: Ok.

Ex. A, 00562-72 (underlined emphasis added)

Combined Insurance did not send either Trudy or EBMS information verifying the existence, nature or time frames of their insurance coverage for Trudy before she had her medical treatment in October 1999.

Trudy's surgery was performed as scheduled and her hospitalization at St. Mark's Hospital continued through the date of her death, November 4, 1999. The total amount of those medical bills is $144,380.85.

St. Mark's Hospital and other providers for Trudy submitted their bills to EBMS for processing and payment. On December 16, 1999, EBMS denied payment and sent Explanations of Benefit (EOBs) stating:

> PRE-EXISTING CONDITIONS ARE NOT COVERED
> PLEASE REFER TO YOUR PLAN BOOKLET PAGE (S) 24

Ex. A, at D000574 - 624.

On March 14, 2000, Mr. Stegelmeier wrote to EBMS, requesting reconsideration of the denial of payment. Ex. A, D003 84.

EBMS wrote to Mr. Stegelmeier on April 4, 2000, and upheld its denial of payment based on the pre-existing condition exclusion. Ex. A, D00383.22. On May 1, 2000, he wrote again to EBMS to appeal the denial. He noted in his letter that he and Trudy had relied on EBMS's pre-authorization for the surgery in making their decision to move forward with the procedure. Ex. A, D00386.23.

An EBMS internal handwritten page begins with a note dated May 12, 2000, in which "Bette" asks "Kellie" for a "copy of book & ins." Kellie responds on May 15, 2000, noting that "This is second request (appeal). Attached is letter sent before — this is a huge case and we've already responded. Let me know if you need anything else." On May 19, 2000, Bette writes to "Wanda" "On 2nd appeals, do we just deny again? or do we send it to the Plan Administrator?" The last dated note of June 20, 2003, states: "Per Heber Andrus — deny as pre-exist - can't make exception to Plan. Bette." EBMS initially drafted a response to Mr. Stegelmeier's second appeal in a letter dated June 21, 2000, in which

it upheld its denial. The draft was not finalized and sent, but rather, the matter was referred to the Plan's administrator, Heber Andrus, for a final decision. Ex. A, D00385.

EBMS wrote to Heber Andrus, in his capacity as Plan Administrator, on June 22, 2000, requesting a review of the claim and a final decision. EBMS included pages of the Plan Booklet and copies of the April 4, 2000, letter to Plaintiff, along with a copy of a letter to him dated June 22, 2000, which informed him that the plan administrator was reviewing the claim. Ex. A at D00381-382.

On June 28, 2000, Claims Management, Inc. (CMI) wrote to the Plan and requested reconsideration of the denial. Included with the letter was an authorization from St. Mark's Hospital, indicating that CMI was its authorized representative for purposes of appealing the denial of payment. Ex. A, at D00378-80.

On August 28, 2000, Mr. Andrus responded on behalf of the Plan upholding the denial based on the exclusion in the policy for coverage of pre-existing conditions. Ex. A, D00330.

Mr. Andrus's affidavit states that he and an EBMS employee discussed the pre-existing issue and the denial of benefits in mid to late March 2000:

> We also discussed that the treatment could have nevertheless been covered if Trudy had provided verification of creditable coverage that was in place at the time Trudy became covered by the Plan. We discussed that Trudy had never provided any such verification.

Andrus Aff. at ¶ 5 (underlined emphasis added). He further represents:

> Based upon the information that was provided to me by EBMS . . . I instructed the EBMS employee to deny Stegelmeier's appeal. I informed the

> EBMS employee that the pre-existing condition and lack of creditable coverage precluded the Plan from providing benefits. . . . I told the EBMS employee that I could not make an exception to the provision of the Plan. At the time that I made the decision, I still had not been provided with any documentation regarding previous insurance coverage for – creditable or otherwise. The EBMS employee informed me that the EBMS had also not received any such verification.

Id. at ¶ 6 (underlined emphasis added).

According to Mr. Andrus' affidavit, he discussed the issue with EBMS again in June 22, 2000, and instructed them to again deny based on the lack of documentation for previous insurance. *Id.* at ¶¶ 7-8. Again on August 28, 2000, he instructed Doug Andrus to uphold the denial of benefits, again based on the lack of documentation of previous insurance coverage. *Id.* at ¶ 9.

None of the letters to Mr. Stegelmeier about the claims, from either EBMS or the Plan Administrator, inform him that the denial is because he failed to provide a certificate or other verification showing prior creditable coverage.

Plaintiff's counsel wrote to EBMS on March 5, 2001, as attorney for St. Mark's Hospital and for Mr. Stegelmeier. Counsel requested copies of all claims submitted to EBMS in 1999, copies of all EOBs sent either to Trudy or to her health care provider for services in 1999, a copy of the plan document and a copy of the SPD. EBMS did not respond in writing to the March 5, 2001, letter. On March 19, 2001, Plaintiff's counsel wrote again to EBMS regarding the existence of prior creditable coverage and again requesting copies of the plan document and SPD. Enclosed was a copy of the letter from

Combined dated March 8, 2001. Neither the Plan nor its agent, EBMS, produced a copy of the Plan or SPD documents requested by Plaintiff's counsel prior to this litigation.

EBMS responded to Mr. King in a letter dated April 24, 2001, in which it requested a copy of the Combined insurance policy. EBMS had indicated in a telephone call to Mr. King that it would not provide copies of any of the requested documents without a release from Stegelmeier, and it reiterated its request in the April 24, 2001, letter. On July 31, 2001, Mr. King sent to EBMS a letter which included copies of the Combined insurance policies and which addressed the fact that there was no need for Mr. King, as attorney for St. Mark's Hospital and Stegelmeier, to produce a release to EBMS prior to receiving requested information. EBMS wrote to Mr. King on August 20, 2001, and noted its receipt of the July 31, 2001, letter. However, EBMS failed to produce a copy of the requested documents. On October 8, 2001, Mr. King wrote again to EBMS and included copies of both Combined insurance policies which covered Trudy from 1997 through the date of her death. In the letter, Mr. King discussed the issue of creditable coverage and the Combined insurance policies. EBMS did not respond in writing to the October 8, 2001, letter from Mr. King.

III. DISCUSSION AND CONCLUSIONS

A. Summary Judgment Standard

The standard for summary judgment is well-known,

> "When applying this standard, we view the evidence and draw reasonable inferences therefrom in the light most favorable to the nonmoving party." *English v. Colo. Dep't of Corr.*, 248 F.3d 1002, 1007 (10th Cir.2001)(quotation

> omitted). Summary judgment is appropriate only if the evidence shows "there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c) (emphasis added). To successfully oppose summary judgment, the nonmoving party must show that there is a "genuine" issue of fact, which requires "more than simply show[ing] that there is some metaphysical doubt as to the material facts." *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586, (1986). "As to materiality, the substantive law will identify which facts are material. Only disputes over facts that might affect the outcome of the suit under the governing law will properly preclude the entry of summary judgment. Factual disputes that are irrelevant or unnecessary will not be counted." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986).

Bartell v. Aurora Public Schools, 263 F.3d 1143, 1146 (10th Cir. 2001).

The parties agree that the material facts are undisputed and center their arguments on the result of those facts.

B. The Positions of the Parties

Plaintiff filed this suit under ERISA and HIPPA seeking coverage for Trudy Stegelmeier's medical and hospital bills incurred in her final hospitalization. He seeks summary judgment on his claims and contends that because ERISA's notice provisions were not complied with, this court should apply a *de novo* standard of review of the Plan Administrator's denial of the claims and consider evidence not submitted to the defendants until eighteen months after the initial denial of claims. Plaintiff contends that the evidence shows prior creditable coverage. Plaintiff also seeks statutory penalties for the failure to comply with ERISA's disclosure provisions as well as attorney's fees and costs.

Defendants are the Plan and the Plan Administrator, who reviewed and upheld the denials. Defendants contend that because the Plan gives the Plan Administrator

discretionary authority to determine claims, that the arbitrary and capricious standard of review applies. Defendants contend that under that standard, the claim was properly denied on the basis of pre-existing condition, the appeal of the denial was timely and properly denied, review should be limited to the materials before the Plan Administrator when he first reviewed the denial and that there was substantial compliance with ERISA. Defendants also contend that the claim for statutory penalty claims should be denied.

C. Standard of Review for Denial of Claims

In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, (1989), the Supreme Court ruled that a denial of benefits under ERISA's § 1132(a)(1)(B) should be reviewed under a *de novo* standard *unless* the insurance contract gave the administrator discretionary authority to determine eligibility for such benefits. *Hickman v. GEM Ins. Co.*, 299 F.3d 1208, 1215 (10th Cir. 2002). Where the Plan Administrator has full discretion to determine eligibility for benefits, this court properly reviews a decision to deny benefits under the arbitrary and capricious standard. *Id.* and *Jones v. Kodak Medical Assistance Plan*, 169 F.3d 1287 (10th Cir. 1999).

While the Plan at issue in this case clearly provides full discretionary authority to determine eligibility, Plaintiff relies on the case *Gilbertsons v. Allied Signal, Inc.*, 328 F.3d 625 (10th Cir. 2003), for the proposition that, where the plan administrator did not substantially comply with certain of ERISA's procedural requirements, so that the claim was "deemed denied," then that administrator did not exercise his discretion under the plan and no deference was afforded to his decision.

At issue in *Gilbertsons* was the failure of the Plan Administrator to render *any* decision on an appeal of the denial of claims for six months. 328 F.3d at 629. Under federal regulations applicable to ERISA cases, a plan administrator must ordinarily issue a written a decision on an appeal within 60 to 120 days, or it is "deemed denied" and the claimant will be considered to have exhausted administrative remedies. *Id.* at 625-26 citing 29 C.F.R. § 2560.503-1(h)(1).

Plaintiff notes that subsection (h)(3) of the same regulation also requires that the administrator's written decision "shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, as well as specific references to the pertinent plan provisions on which the decision is based." Plaintiff contends that because Defendants failed to provide adequate notice as required in that subsection and other ERISA provisions, that the claim was "deemed denied" and a *de novo* standard is appropriate.

Plaintiff's position reads *Gilbertsons* and the regulations it relies on too broadly. Subsection (h)(1)(4) of § 2560.503, in providing for the "deemed denied" status of untimely appeal decisions refers specifically only to the failure to furnish the decision on review to the claimant within the appropriate time described in (h)(1):

> The decision on review shall be furnished to the claimant within the appropriate time described in (h)(1) of this section. If the decision on review is not furnished within such time, the claim shall be deemed denied on review.

Id.

In the present case, the Plan Administrator provided written notice of his decision on several occasions, as set forth above. There is no comparable ERISA statutory or regulatory provision authorizing "deemed denied" status for the failure to provide timely, but inadequate, notice of the denial of claims and of decisions on review of such denials. Therefore, the court must reject Plaintiff's claim for a *de novo* review under *Gilbertsons*.

C. Administrative Appeal Period

As noted above, the parties dispute the effect of the facts in this case. Defendants contend that the administrative appeal period closed 60 days after the denial of benefits, and that all subsequent actions by or on behalf of Plaintiff were untimely. Plaintiff contends that the administrative appeal period never did run before this suit was filed because Defendant failed to comply with the notice provisions that trigger the running of the period.

It is clear that all of the EOBs and letters notifying Plaintiff of the denial of the claims and denial of review notices sent by defendants to Mr. Stegelmeier failed to comply with ERISA and HIPPA requirements. The requirements are found at 29 U.S.C. § 1133(1) (in accordance with regulations, every Plan shall provide written notice of specific reason for denial) and 29 C.F.R. § 2560.503-1(f). Section 2560.503-1(f) provisions are nearly identical to the Plan provisions, quoted above at 4, under the section: When Claims Should be Filed. The EOBs failed to give Mr. Stegelmeier any notice of the appeals process or its time limitations or that the reason for the denial of benefits under the pre-existing conditions provision was the lack of proof of creditable coverage. This failure was

compounded by the subsequent failure of the letters of either the Claims Administrator or the Plan Administrator to ever provide adequate notice that the claims were being denied due to the lack of verification of creditable coverage. The failure to provide such required information in the notices is especially serious when, according to Mr. Andrus' affidavit, he considered and discussed with the Claims Administrator the lack of verification of creditable coverage each of the three times he reviewed the denial of benefits.

Defendants are correct that substantial compliance, rather than technicalities, is the standard for ERISA and its regulations. *Sage v. Automation Incorporated Pension Plan and Trust*, 845 F.2d 885 (10th Cir. 1988). However, in this case, there was much more than a minor failure to comply, there was a complete failure to provide two necessary categories of information–the appeals procedures and the full reason for the denial (the lack of verification of creditable coverage). Further, where the Plan and the regulation require that review process information be included in the written notice to the claimant at the time of denial, it is irrelevant that the information was also included in the 58-page Plan Document and SPD. Any other position would render those provisions meaningless.

Because of the lack of notice that it was the lack of verification of creditable coverage issue that was the reason for the denial, it is hardly surprising that Mr. Stegelmeier failed to provide such verification when the denial was first reviewed. Plaintiff cites cases from other circuits for the proposition that the Defendants' failure to comply with the claims notice requirements should relieve Plaintiff of his correspondent duties under

the administrative appeal process. *See Conley v. Pitney Bowes*, 34 F.3d 714, 718 (8th Cir. 1994).

However, it appears that, where the plan administrator fails to comply with ERISA's procedural guidelines by failing to provide adequate notice, the appropriate remedy is to remand to the plan administrator for a redetermination of the claim.

> Section 1133(1) requires that a claims administrator provide adequate notice to any participant whose claim has been denied, "setting forth the specific reasons for such denial...." 29 U.S.C. § 1133(1). No such reasons appear in the [Plan] administrator's letter. The remedy when an ERISA administrator fails to make adequate findings or to explain adequately the grounds of her decision is to remand the case to the administrator for further findings or explanation. A remand for further action is unnecessary only if the evidence clearly shows that the administrator's actions were arbitrary and capricious, or the case is so clear cut that it would be unreasonable for the plan administrator to deny the application for benefits on any ground.

Caldwell v. Life Ins. Co. of North America, 287 F.3d 1276, (10th Cir. 2002) *See Wertheim v. Hartford Life Ins. Co.*, 268 F.Supp.2d 643, 660 (E.D. Va. 2003) (collecting cases).

In the present case, both the Claims Administrator and the Plan Administrator failed to give adequate notice of the denial of claims. Because the court is remanding the case, there is no need to resolve the parties' dispute over when, or if, the appeal process began because a new appeal process will begin when the Claims Administrator sends Mr. Stegelmeier a prompt and adequate notice that includes, among other required information, "a description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary." Ex. B.

D. Disability Insurance

Defendants contend that, if this court should reach Plaintiff's claims on the merits, they should be denied because there is no creditable coverage. The court construes this as a claim that remand would be futile because the Combined policies are not "creditable coverage."

Under HIPPA, in furtherance of its purpose of increasing the portability of health insurance, health insurers may not exclude an individual with pre-existing condition if he or she has 18 months of "creditable coverage" with a prior insurer. 29 U.S.C. § 1181. Such "creditable coverage" is defined in the federal regulations and proof of such coverage may be furnished by several means, including by a certificate showing date and duration or certain other substituting documentation. 29 C.F.R. § 2590.701-5.

As pointed out by Defendants, disability policies are "excepted benefits" excluded from HIPPA's definition of creditable coverage. 29 C.F.R. § 2590.732(b)(2)(ii) (disability income insurance is excepted benefit). However, as pointed out by Plaintiff, Section E of one of the Combined policies contains benefits payable for a hospitalization, without any tie to disability. Plaintiff contends that this is "creditable coverage."

Where part of the coverage under section E of one of the Combined policies is not clearly a "disability policy," the issue of proof of "creditable coverage" is more properly addressed by the Claims Adjustor and the Plan Administrator on remand.

E. Statutory Penalties

Plaintiff seeks summary judgment on his claims for statutory penalties for the failure to provide plan documents when requested in writing by his counsel. 29 U.S.C. § 1024(b)(4) requires that such documentation be provided upon written request even if the participant received the materials in the past. *Moothart v. Bell*, 21 F.3d 1499, 1504 n. 4 (10th Cir. 1994). The statutory penalties for the failure to comply within 30 days of the request is up to $110 a day.

Plaintiff is correct that the Plan Administrator can be liable for its agent, EBMS's refusal to comply. *Wilcott v. Matlock*, 64 F.3d 1480 (10th Cir. 1994). Similarly, it is clear that an attorney is entitled to request and receive the documents on a participant's behalf. *Moothart*, 21 F.3d at 1503.

On July 31, 2001, Plaintiff's attorney sent a letter request for the materials citing the *Moothart* case and attaching a copy as authority for his request on Plaintiff's behalf. If the court determines that statutory penalties are appropriate, they would run from that date.

Defendants contend that the request was not timely since it was raised so long after the first denial of his administrative appeal. They further contend that an award is not appropriate since their failure to provide the documents was not in bad faith and the materials were available in the offices of Andrus Distributing.

However, "neither prejudice nor injury are prerequisites to recovery under the penalty provisions of the statute. Instead, these are factors the district court may consider in deciding to award a penalty." *Moothart*, 21 F.3d at 1506 (internal citations omitted).

The court believes that the issue of statutory penalties will be more appropriately addressed after the remand when prejudice, injury and other factors may be fully considered.

F. Attorneys Fees and Costs

The issue of an award of attorneys fees and costs under ERISA is also more appropriately addressed after the remand. The court will administratively close this case pending re-determination of the claims.

IV. ORDER AND CONCLUSION

Based upon the foregoing it is therefore

ORDERED that Plaintiff's Motion for Summary Judgment is DENIED without prejudice. It is further

ORDERED that this case is REMANDED to the Plain Administrator. The Plan Administrator shall send the claims to the Claims Administrator for prompt consideration of the claims and for compliance with notice requirements for any denial of those claims. If Plaintiff seeks any denial of said claims, the Plan Administrator shall comply with the procedural requirements of the Plan and ERISA. It is further

ORDERED that this case is administratively closed, subject to a motion to re-open by any party.

DATED this 12th day of January, 2004.

BY THE COURT:

TED STEWART
United States District Judge

jmr

United States District Court
for the
District of Utah
January 12, 2004

* * CERTIFICATE OF SERVICE OF CLERK * *

Re: 2:02-cv-00238

True and correct copies of the attached were either mailed, faxed or e-mailed by the clerk to the following:

Michael D. Gaffney, Esq.
BEARD ST CLAIR GAFFNEY MCNAMARA CALDER
2105 CORONADO
IDAHO FALLS, ID 83404

Mr. Brent R. Armstrong, Esq.
ARMSTRONG LAW OFFICES
STE 150 BANK ONE TOWER
50 W 300 S
SALT LAKE CITY, UT 84101-2006

Ms. Karra J Porter, Esq.
CHRISTENSEN & JENSEN PC
50 S MAIN STE 1500
SALT LAKE CITY, UT 84144
JFAX 9,3553472

Mr. Brian S King, Esq.
336 S 300 E STE 200
SALT LAKE CITY, UT 84111
EMAIL